

**THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.**

## VON WILLEBRAND (VWD) TESTING PATIENT HISTORY FORM

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Sex:**  Female  Male  
**Ordering Provider:** \_\_\_\_\_ **Provider's Phone:** \_\_\_\_\_  
**Practice Specialty:** \_\_\_\_\_ **Provider's Fax:** \_\_\_\_\_  
**Genetic Counselor:** \_\_\_\_\_ **Counselor's Phone:** \_\_\_\_\_

**Patient's Ethnicity/Ancestry** (check all that apply)

African American/Black  Asian  Hispanic  White  Other: \_\_\_\_\_

**List country of origin (if known):** \_\_\_\_\_

**Does the patient have a suspected diagnosis of VWD?** .....  No  Yes (specify type below)  Unknown  
 Type 1  Type 2A  Type 2B  Type 2M  Type 2N  Type 3  Pseudo VWD  Acquired VWD

**Does the patient have symptoms?** .....  No  Yes (check all that apply)  Unknown  
 Excessive bruising  Hematuria  Prolonged bleeding after childbirth  
 Gastrointestinal bleeding  Intracranial hemorrhage  Prolonged bleeding post-surgery  
 Hemarthrosis  Menorrhagia  Prolonged repeated nosebleeds  
 Hematomas  Post tooth extraction bleeding  Other symptom(s): \_\_\_\_\_

**Indicate disease severity in the patient:** .....  NA  Mild  Moderate  Severe  Unknown

**Laboratory Findings—Hemostasis factor assays:**

Factor VIII: .....	_____ %	<input type="checkbox"/> Normal	<input type="checkbox"/> Low	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
VWF: RCo (ristocetin cofactor activity) ....	_____ %	<input type="checkbox"/> Normal	<input type="checkbox"/> Low	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
VWF: Ag (quantity of antigen) .....	_____ %	<input type="checkbox"/> Normal	<input type="checkbox"/> Low	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
VWF: CB (collagen binding) .....	_____ %	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
VWF: FVIII B (Factor VIII binding) .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
RIPA: Ristocetin-induced platelet agglutination .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not performed
VWF Multimer Pattern .....		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (describe: _____)		

**Has the patient undergone previous DNA testing?** .....  No  Yes  Unknown  
 If yes, describe the test(s) and results: \_\_\_\_\_

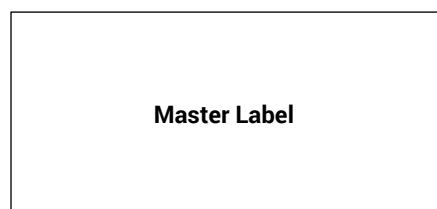
**Is there any relevant family history?** .....  No  Yes  Unknown

**If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:**

**Has DNA testing been performed for the family member(s)?** .....  No  Yes  Unknown  
**If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).**

**Check the test you intend to order.**

- 3004379 von Willebrand Disease (VWF) Sequencing:** Clinical sensitivity 80% for VWD type 1 and 90% for VWD types 2 and 3.
- 2001961 Familial Mutation, Targeted Sequencing:** Tests for a sequence variant previously identified in a family member; a copy of a relative's lab result is REQUIRED



**For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.**